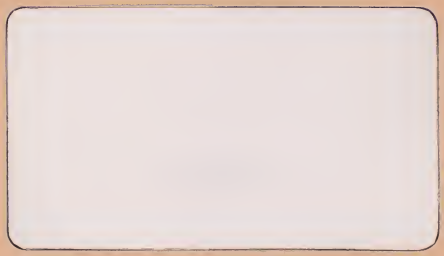
Health Care Financing

RESEARCH BRIEF

These brief reports from the Office of Research, Office of Research and Demonstrations, provide Medicare and Medicaid program information on current health care issues.

They are based on data from the Medicare statistical files developed and maintained by the Bureau of Data Management and Strategy, Health Care Financing Administration



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Research Brief No. 86 - 4
Medicare: Use of Skilled Nursing Facilities, 1984

Medicare: Use of Skilled Nursing Facilities, 1984

The skilled nursing facility (SNF) benefit under the Medicare program was established by Congress, effective January 1, 1967. It provides a limited period of skilled nursing care or other rehabilitation services. The intent of the law was to provide a less expensive level of inpatient acute follow-on care to reduce short-stay hospital inpatient length of stay, thereby cutting costs to the Medicare program.

The Medicare law provides for up to 100 days of inpatient care in a SNF during a benefit period. The first 20 days in a SNF are paid in full. For the remaining 80 days, the patient is responsible for coinsurance payments each day equal to one-eighth of the current inpatient hospital deductible. The law stipulates that to be a covered SNF admission, the following criteria must be met:

- The patient requires daily skilled nursing care and/or skilled rehabilitation services.
- The patient has a medically necessary stay in a participating hospital for at least 3 days.
- The doctor certifies that the patient needs such care, and the care is for a condition treated during the qualifying hospital stay.
- The patient transfers to a SNF within 30 days of discharge from the hospital (the original 14-day requirement has been changed to 30 days).

The short-stay hospital inpatient benefit has dominated the use of Part A services, accounting annually for about 95 percent of all Part A expenditures. Medicare SNF benefits have consistently accounted for only a small and decreasing proportion of Medicare expenditures, ranging from a high of 5.3 percent in 1969 to a low of only 0.8 percent in 1984. The infrequent use of SNF services during this period was generally attributed to the limited nature of the benefit and restrictive Medicare administrative regulations governing covered levels of care in SNF's. These regulations reflect the congressional view that Medicare SNF benefits are not intended for the purpose of providing long-term SNF care. The relatively small amount of Medicare SNF expenditures, especially in recent years, has led to the speculation that the SNF benefit is not being used to the extent it was intended by Congress.

The new Medicare prospective payment system (PPS), however, has altered the incentives with respect to the use of SNF care. The incentive for short-stay hospitals under PPS is to discharge patients sooner than they would have been discharged under the previous retrospective cost-based payment system. It is likely, therefore, that hospitals will attempt to increase the use of nursing homes under Medicare.

The primary purpose of this Brief is to provide program data for aged and disabled Medicare beneficiaries admitted to SNF's in order to measure, evaluate, and monitor the impact of PPS on the use and cost of services in participating SNF's. The data contained in the tables should provide information to help identify trends and patterns of SNF use which affect, to a large degree, the amount of expenditures for benefits. With only 1 year of post-PPS data, however, it is too early to definitively identify, analyze, and evaluate utilization patterns and trends.

This Research Brief was prepared in the Division of Program Studies of the Office of Research. For additional information call Will Kirby at (301) 597-6149 or FTS 987-6149. For suggestions regarding future topics, call Charles Helbing at (301) 597-1420 or FTS 987-1420.

Selected Data Highlights

Table 1 - Trends in Utilization of Medicare SNF Services by Hospital Insurance Beneficiaries: Selected Years 1971-84

- The SNF covered days of care (CDOC) used by Medicare beneficiaries increased from 7.5 million in 1971 to 9.6 million in 1977. Between 1977 and 1979, the SNF CDOC dropped sharply to 8.3 million, but then rose steadily to 9.0 million in 1983. In 1984, however, the SNF CDOC dropped slightly to 8.9 million.

- Total reimbursements for Medicare SNF services increased from $179 million in 1971 to $465 million in 1984, an average annual rate of increase of 7.6 percent (Figure 1). SNF reimbursements, as a percent of total Medicare expenditures, dropped steadily from 2.4 percent in 1971 to 0.8 percent in 1984.

- The average Medicare SNF expenditure per day rose from $24 in 1971 to $52 in 1984 (Figure 2).

Table 2 - Utilization of Medicare SNF Services: Geographic Characteristics, 1984

- For all areas, the 332,700 SNF admissions in 1984 accounted for 8.9 million CDOC, an average CDOC of 26.6 days per admission. The annual CDOC rate was 296 per 1,000 enrollees.

- The North Central displayed the highest annual CDOC rate (362 per 1,000 enrollees) among the four United States census regions, reflecting the second highest discharge rate (14 per 1,000 enrollees) and an average CDOC per admission (26.6) equal to that for all areas.

- In contrast, the South had the lowest CDOC rate (236 per 1,000), reflecting the lowest discharge rate (8 per 1,000), which was about 38 percent below the national average (11 per 1,000).

- Among the States, the annual CDOC rate per 1,000 enrollees ranged from 55 in Mississippi to 574 in Pennsylvania, a difference of 944 percent.

- Among the four regions, the average covered charge per admission ranged from $2,692 in the West to $3,401 in the Northeast, a difference of 26 percent. By State, the average covered charge per admission ranged from $1,254 in Idaho to $5,713 in Alaska, a difference of 356 percent.

- The average CDOC per admission varied substantially among the regions, ranging from a low of 20.7 days in the West to 31.6 days in the Northeast, a difference of 53 percent. Among the States, the average CDOC ranged from 16.4 days in Iowa to 40.0 days in South Carolina, a difference of 144 percent.

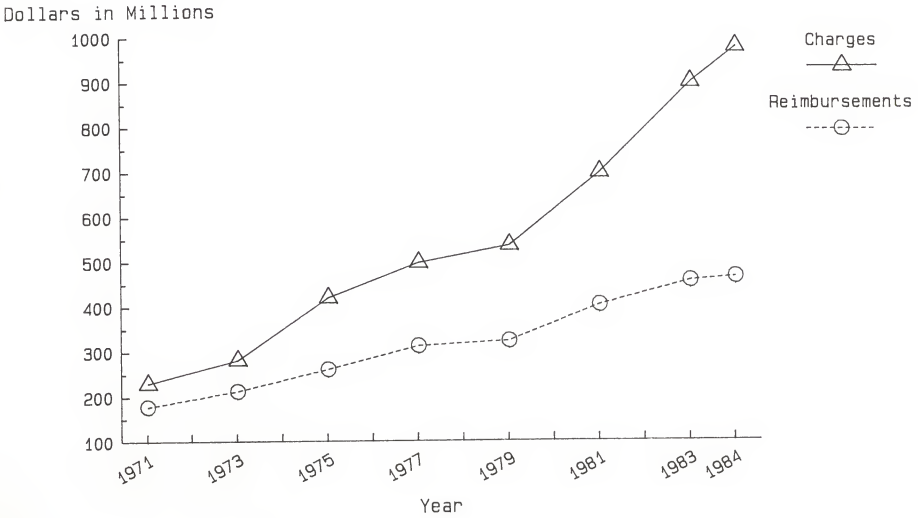
TABLE 1

USE OF SKILLED NURSING FACILITY SERVICES BY MEDICARE HOSPITAL INSURANCE BENEFICIARIES: COVERED DAYS OF CARE, COVERED CHARGES, AND REIMBURSEMENT BY SELECTED CALENDAR YEARS, 1971 - 1984

SELECTED CALENDAR YEARS	COVERED DAYS OF CARE		COVERED CHARGES		REIMBURSEMENTS					
	NUMBER IN THOUSANDS	PER 1,000 ENROLLEES	AMOUNT IN THOUSANDS	PER DAY	TOTAL MEDICARE IN THOUSANDS	SKILLED NURSING FACILITY IN THOUSANDS	PERCENT OF COVERED CHARGES	PERCENT OF TOTAL MEDICARE REIMBURSEMENTS	PER ENROLLEE	PER DAY
ALL BENEFICIARIES										
1971	7,481	361	$229,912	$31	$7,486,953	$178,703	77.7	2.4	$8.62	$24
1973	8,629	370	282,091	33	9,639,206	212,761	75.4	2.2	9.13	25
1975	8,874	360	420,305	47	14,746,886	261,058	62.1	1.8	10.59	29
1977	9,612	368	497,553	52	21,094,334	312,703	62.8	1.5	11.98	33
1979	8,294	302	535,718	65	28,267,017	323,721	60.4	1.1	11.79	39
1981	8,575	300	697,306	81	41,021,962	402,984	57.8	1.0	14.10	47
1983	9,032	305	897,158	99	54,894,513	456,352	50.9	0.8	15.42	51
1984	8,864	296	975,362	110	56,761,299	464,796	47.7	0.8	15.50	52
AGED										
1971	7,481	361	229,912	31	7,486,953	178,703	77.7	2.4	8.62	24
1973	8,523	395	278,065	33	9,218,271	209,838	75.4	2.3	9.73	25
1975	8,585	382	405,547	47	13,178,458	251,506	62.0	1.9	11.19	29
1977	9,278	395	477,611	51	18,518,654	300,452	62.9	1.6	12.80	32
1979	7,988	325	513,397	64	24,491,108	310,488	60.4	1.3	12.65	39
1981	8,269	323	668,904	81	35,521,279	387,331	57.9	1.1	15.14	47
1983	8,738	328	864,565	99	47,949,283	440,705	51.0	0.9	16.52	50
1984	8,578	316	940,169	110	49,999,211	449,327	47.8	0.9	16.57	52
DISABLED										
1975	289	133	14,758	51	1,568,428	9,552	64.7	0.6	4.41	33
1977	334	128	19,942	60	2,575,680	12,251	61.4	0.5	4.68	37
1979	306	105	22,321	73	3,775,909	13,233	59.2	0.4	4.55	43
1981	306	102	28,402	93	5,500,675	15,653	55.1	0.3	5.22	51
1983	293	101	32,594	111	6,945,230	15,647	48.0	0.2	5.36	53
1984	286	99	35,193	123	6,762,087	15,469	44.0	0.2	5.36	54

Figure 1

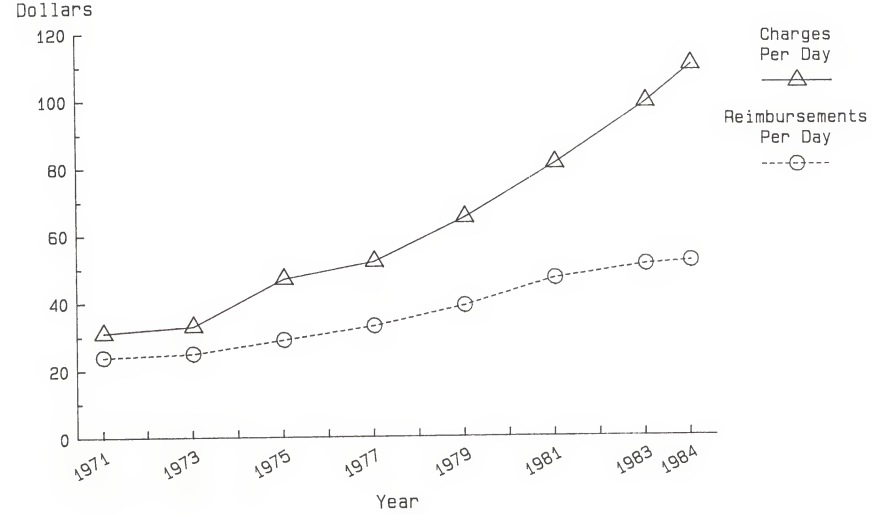
Medicare: Covered Charges and Reimbursements for Beneficiaries Admitted to Skilled Nursing Facilities by Calendar Years, 1971-1984



Source: HCFA/ORD

Figure 2

Medicare: Average Covered Charge Per Day and Average Reimbursement Per Day for Beneficiaries Admitted to SNF'S by Calendar Years, 1971-1984



Source: HCFA/ORD

TABLE 2

USE OF SKILLED NURSING FACILITY SERVICES BY MEDICARE HOSPITAL INSURANCE BENEFICIARIES: NUMBER OF COVERED ADMISSIONS 1/, COVERED DAYS OF CARE, COVERED CHARGES, AND REIMBURSEMENT BY REGION, DIVISION AND STATE, 1984

GEOGRAPHIC CHARACTERISTICS	COVERED ADMISSIONS		COVERED DAYS OF CARE			COVERED CHARGES			REIMBURSEMENT			
	NUMBER	PER 1,000 ENROLLEES	TOTAL IN THOUSANDS	PER 1,000 ENROLLEES	PER ADMISSION	AMOUNT IN THOUSANDS	PER ADMISSION	PER DAY	AMOUNT IN THOUSANDS	PERCENT OF COVERED CHARGES	PER ADMISSION	PER DAY
ALL AREAS	332,746	11	8,864	296	26.6	$975,362	$2,931	$110	$464,796	47.7	$1,397	$52
UNITED STATES	332,302	12	8,856	323	26.7	974,584	2,933	110	464,414	47.7	1,398	52
NORTHEAST	68,259	10	2,160	316	31.6	232,142	3,401	107	106,285	45.8	1,557	49
NORTH CENTRAL	103,930	14	2,762	362	26.6	303,154	2,917	110	141,634	46.7	1,363	51
SOUTH	81,495	9	2,306	236	28.3	227,612	2,793	99	104,326	45.8	1,280	45
WEST	78,618	15	1,628	321	20.7	211,675	2,692	130	112,170	53.0	1,427	69
NEW ENGLAND	11,944	7	325	188	27.2	35,958	3,010	111	18,506	51.5	1,549	57
CONNECTICUT	4,017	11	121	286	25.1	10,064	2,089	83	4,939	49.1	1,025	41
MAINE	764	5	21	126	27.2	3,132	4,100	151	1,509	48.2	1,975	73
MASSACHUSETTS	3,287	4	95	118	28.9	13,738	4,179	145	7,756	56.5	2,360	82
NEW HAMPSHIRE	1,080	9	27	222	26.0	3,447	3,347	129	1,717	49.8	1,667	64
RHODE ISLAND	1,641	11	50	343	30.3	4,384	2,672	88	1,945	44.4	1,185	39
VERMONT	405	6	12	175	29.2	1,187	2,931	100	639	53.9	1,579	54
MIDDLE ATLANTIC	56,315	11	1,835	359	32.6	196,189	3,484	107	87,779	44.7	1,559	48
NEW JERSEY	6,834	7	213	215	31.2	25,691	3,759	120	11,862	46.2	1,736	56
NEW YORK	19,084	8	606	257	31.7	67,199	3,521	111	30,377	45.2	1,592	50
PENNSYLVANIA	30,397	17	1,016	574	33.4	103,299	3,398	102	45,539	44.1	1,498	45
EAST NORTH CENTRAL	74,919	14	2,121	408	28.3	221,626	2,958	104	97,136	43.8	1,297	46
ILLINOIS	24,180	17	668	477	27.6	76,403	3,160	114	34,694	45.4	1,435	52
INDIANA	10,528	15	301	441	28.5	27,429	2,605	91	12,224	44.6	1,161	41
MICHIGAN	16,780	15	502	457	29.9	47,227	2,814	94	18,373	38.9	1,095	37
OHIO	16,664	12	450	330	27.0	50,962	3,058	113	23,824	45.8	1,400	52
WISCONSIN	6,767	10	200	308	29.6	19,605	2,897	98	8,522	43.5	1,259	43
WEST NORTH CENTRAL	29,011	12	641	262	22.1	81,529	2,810	127	44,498	54.6	1,534	69
IOWA	6,383	15	104	243	16.4	15,114	2,368	145	8,364	55.3	1,310	80
KANSAS	2,784	8	57	168	20.3	6,437	2,312	114	3,006	46.7	1,080	53
MINNESOTA	4,067	8	82	152	20.0	10,088	2,480	124	5,035	49.9	1,238	62
MISSOURI	10,617	15	272	377	25.6	37,180	3,502	137	21,133	56.8	1,990	78
NEBRASKA	2,668	12	69	310	26.0	7,909	2,964	114	4,814	60.9	1,804	69
NORTH DAKOTA	1,998	22	46	503	22.9	3,795	1,899	83	1,769	46.6	885	39
SOUTH DAKOTA	494	5	11	108	22.2	1,006	2,037	92	377	37.4	762	34
SOUTH ATLANTIC	47,786	9	1,460	285	30.6	133,033	2,784	91	60,040	45.1	1,256	41
DELAWARE	637	9	24	325	37.6	1,721	2,702	72	721	41.9	1,133	30
DIST. OF COLUMBIA	374	5	11	151	29.6	1,173	3,136	106	622	53.1	1,664	56
FLORIDA	25,618	13	752	396	29.4	71,808	2,804	95	33,656	46.9	1,314	45
GEORGIA	4,165	7	94	151	22.6	10,209	2,451	108	4,450	43.6	1,068	47
MARYLAND	2,504	5	68	150	27.3	5,823	2,326	85	3,019	51.8	1,206	44
NORTH CAROLINA	5,387	7	183	247	34.0	14,871	2,760	81	6,149	41.4	1,141	34
SOUTH CAROLINA	3,060	8	122	340	40.0	8,014	2,619	65	2,801	35.0	915	23
VIRGINIA	4,140	7	143	237	34.7	14,317	3,458	100	6,534	45.6	1,578	46
WEST VIRGINIA	1,906	7	62	219	32.3	5,098	2,675	83	2,088	41.0	1,095	34

TABLE 2 (CONTINUED)

USE OF SKILLED NURSING FACILITY SERVICES BY MEDICARE HOSPITAL INSURANCE BENEFICIARIES: NUMBER OF COVERED ADMISSIONS 1/, COVERED DAYS OF CARE, COVERED CHARGES, AND REIMBURSEMENT BY REGION, DIVISION AND STATES, 1984

GEOGRAPHIC CHARACTERISTICS	COVERED ADMISSIONS		COVERED DAYS OF CARE			COVERED CHARGES			REIMBURSEMENT			
	NUMBER	PER 1,000 ENROLLEES	TOTAL IN THOUSANDS	PER 1,000 ENROLLEES	PER ADMISSION	AMOUNT IN THOUSANDS	PER ADMISSION	PER DAY	AMOUNT IN THOUSANDS	PERCENT OF COVERED CHARGES	PER ADMISSION	PER DAY
EAST SOUTH CENTRAL	20,498	11	537	280	26.2	48,196	2,351	90	21,443	44.5	1,046	40
ALABAMA	7,585	15	149	292	19.7	11,553	1,523	77	5,128	44.8	675	34
KENTUCKY	4,823	10	133	279	27.6	12,625	2,618	95	5,712	45.2	1,184	43
MISSISSIPPI	848	3	18	55	21.3	1,934	2,163	102	776	42.3	915	43
TENNESSEE	7,242	12	237	392	32.7	22,185	3,063	94	9,832	44.3	1,358	41
WEST SOUTH CENTRAL	13,211	5	308	112	23.3	46,383	3,511	150	22,843	49.2	1,729	74
ARKANSAS	1,626	5	34	97	21.2	3,717	2,286	108	1,580	42.5	972	46
LOUISIANA	3,047	7	61	134	20.1	13,806	4,531	225	6,606	47.8	2,168	108
OKLAHOMA	1,830	4	30	74	16.5	5,854	3,199	193	2,716	46.4	1,484	90
TEXAS	6,708	4	182	119	27.2	23,006	3,430	126	11,941	51.9	1,780	66
MOUNTAIN	14,707	11	304	233	20.6	32,594	2,223	108	17,676	54.1	1,202	58
ARIZONA	3,043	8	60	154	19.6	7,410	2,435	125	4,337	58.5	1,425	73
COLORADO	2,795	10	47	160	16.6	5,237	1,874	113	3,224	61.6	1,154	69
IDAHO	2,017	18	35	311	17.6	2,529	1,254	71	1,368	54.1	678	39
MONTANA	1,830	18	45	436	24.4	5,407	1,862	76	1,538	45.2	841	34
NEVADA	1,094	12	27	290	24.7	2,995	2,738	111	1,558	52.0	1,424	58
NEW MEXICO	846	6	18	126	21.2	2,258	2,668	126	1,087	46.0	1,226	58
UTAH	2,875	22	67	513	23.4	8,337	2,900	124	4,300	51.6	1,496	64
WYOMING	207	5	5	114	24.2	526	2,539	105	313	59.6	1,513	63
PACIFIC	63,911	17	1,324	351	20.7	178,981	2,800	135	94,495	52.8	1,479	71
ALASKA	56	3	2	104	30.1	320	5,713	190	123	38.5	2,200	73
CALIFORNIA	51,664	19	1,061	391	20.5	151,451	2,931	143	78,688	52.0	1,523	74
HAWAII	932	9	26	278	31.7	3,884	4,169	147	2,270	58.4	2,728	86
OREGON	3,421	9	83	229	24.3	8,811	2,576	106	4,525	51.4	1,323	55
WASHINGTON	7,938	15	152	295	19.1	14,515	1,828	96	8,894	61.3	1,120	59
OUTLYING AREAS	444	1	8	13	18.7	779	1,754	94	382	49.0	860	46
PUERTO RICO	384	1	7	17	17.0	613	1,595	94	301	49.1	783	46
OTHER	60	0	2	7	29.5	166	2,771	94	81	49.0	1,356	46

1/ INCLUDES SNF ADMISSIONS WITH AT LEAST ONE DAY OF COVERED CARE UNDER MEDICARE. EXCLUDES STAYS OF BENEFICIARIES WHO HAVE EXHAUSTED THEIR SNF BENEFITS AND FOR WHOM NO DISCHARGE RECORD WAS RECIEVED

Table 3 - Use and Cost of SNF Services by Medicare Hospital Insurance Beneficiaries: Demographic Characteristics, 1984

- Among the aged beneficiaries, the number of SNF CDOC per 1,000 enrollees increased substantially with age. The rate for persons 85 years of age or over (1,010 per 1,000 enrollees) was nearly 16 times greater than the rate for persons aged 65 to 66 (64 per 1,000 enrollees).

- On the other hand, the average CDOC per admission did not vary with age, while the average covered charge per admission declined steadily with age, going from $3,337 for persons under age 65 to $2,756 for persons age 85 or over.

- Females used substantially more SNF services than males. The number of CDOC per 1,000 enrollees was 72 percent higher among females (360) than males (209), reflecting a much higher user rate and a longer average covered length of stay.

- White people used a much higher rate of SNF services than people of all other races. White people used 305 CDOC per 1,000 enrollees compared with 223 per 1,000 for people of all other races, a difference of 37 percent.

Table 4 - SNF Utilization by Medicare Hospital Insurance Beneficiaries: Type of Control, 1984

- Proprietary SNF's furnished more services than any other type of control during 1984, accounting for approximately two-thirds of all SNF covered admissions and CDOC.

- Voluntary SNF's had the highest covered charge per admission ($3,703) and the highest covered charge per day ($141).

Table 5 - SNF Utilization by Medicare Hospital Insurance Beneficiaries: Selected Diagnostic Classifications, 1984

- The 12 selected leading conditions for which Medicare beneficiaries were admitted to a SNF accounted for 99,773 admissions, or about 30 percent of all SNF admissions (332,746).

- Two leading diagnostic classifications--fracture of the hip (ICD-9-CM 820) and acute, but ill-defined, cerebrovascular disease (ICD-9-CM 436)--accounted for nearly one-fifth of all SNF covered admissions and one-third of all covered charges.

- Among the selected leading diagnostic classifications the average number of CDOC per admission ranged from 22.9 days for malignant neoplasm of trachea, bronchus, and lung (ICD-9-CM 162) to 41.5 days for chronic ulcer of skin (ICD-9-CM 707). Similarly, the average charge per admission ranged from $2,345 for heart failure (ICD-9-CM 428) to $4,808 for chronic ulcer of the skin (ICD-9-CM 707).

TABLE 3

USE OF SKILLED NURSING FACILITY SERVICES BY MEDICARE HOSPITAL INSURANCE BENEFICIARIES: NUMBER OF COVERED ADMISSIONS 1/, COVERED DAYS OF CARE, COVERED CHARGES, AND REIMBURSEMENT BY AGE, SEX AND RACE, 1984

DEMOGRAPHIC CHARACTERISTICS	COVERED ADMISSIONS		COVERED DAYS OF CARE			COVERED CHARGES			REIMBURSEMENT			
	NUMBER	PER 1,000 ENROLLEES	TOTAL IN THOUSANDS	PER 1,000 ENROLLEES	PER ADMISSION	AMOUNT IN THOUSANDS	PER ADMISSION	PER DAY	AMOUNT IN THOUSANDS	PERCENT OF COVERED CHARGES	PER ADMISSION	PER DAY
TOTAL	332,746	11	8,864	296	26.6	$975,362	$2,931	$110	$464,796	47.7	$1,397	$52
AGE												
UNDER 65	10,545	4	286	99	27.1	35,193	3,337	123	15,469	44.0	1,467	54
65-66	8,763	2	229	64	26.1	29,043	3,314	127	13,180	45.4	1,504	58
67-68	11,640	3	304	89	26.1	37,649	3,234	124	17,199	45.7	1,478	57
69-70	15,140	5	393	121	25.9	47,733	3,153	122	21,883	45.8	1,445	56
71-72	18,120	6	472	160	26.0	55,938	3,087	119	25,889	46.3	1,429	55
73-74	21,066	8	550	211	26.1	64,856	3,055	117	30,036	46.7	1,426	55
75-79	66,942	13	1,764	340	26.4	198,737	2,969	113	94,907	47.8	1,418	54
80-84	76,979	23	2,066	618	26.8	221,336	2,875	107	106,924	48.3	1,389	52
85 OR OVER	103,551	37	2,801	1,010	27.0	285,376	2,756	102	139,309	48.8	1,345	50
SEX												
MALE	108,605	9	2,664	209	24.5	305,164	2,810	115	143,049	46.9	1,317	54
FEMALE	224,141	13	6,201	360	27.7	670,198	2,990	108	321,747	48.0	1,435	52
RACE												
WHITE	303,062	12	8,003	305	26.4	877,853	2,897	110	419,668	47.8	1,385	52
OTHER	21,478	7	642	223	29.9	73,390	3,417	114	33,497	45.6	1,560	52
UNKNOWN	8,206	10	220	259	26.8	24,119	2,939	110	11,630	48.2	1,417	53

1/ INCLUDES SNF ADMISSIONS WITH AT LEAST ONE DAY OF COVERED CARE UNDER MEDICARE. EXCLUDES STAYS OF BENEFICIARIES WHO HAVE EXHAUSTED THEIR SNF BENEFITS AND FOR WHOM NO DISCHARGE RECORD WAS RECIEVED

TABLE 4

USE OF SKILLED NURSING FACILITY SERVICES BY MEDICARE HOSPITAL INSURANCE BENEFICIARIES: NUMBER OF COVERED ADMISSIONS 1/, COVERED DAYS OF CARE, COVERED CHARGES, AND REIMBURSEMENT BY TYPE OF CONTROL, 1984

TYPE OF CONTROL	COVERED ADMISSIONS	COVERED DAYS OF CARE		COVERED CHARGES			REIMBURSEMENT			
		TOTAL IN THOUSANDS	PER ADMISSION	AMOUNT IN THOUSANDS	PER ADMISSION	PER DAY	AMOUNT IN THOUSANDS	PERCENT OF COVERED CHARGES	PER ADMISSION	PER DAY
SKILLED NURSING FACILITIES	332,746	8,864	26.6	$975,362	$2,931	$110	$464,796	47.7	$1,397	$52
VOLUNTARY	83,187	2,184	26.3	308,077	3,703	141	153,686	49.9	1,847	70
PROPRIETARY	217,649	5,884	27.0	578,292	2,657	98	269,650	46.6	1,239	4
GOVERNMENT	31,910	797	25.0	88,993	2,789	112	41,460	46.6	1,299	52

1/ INCLUDES SNF ADMISSIONS WITH AT LEAST ONE DAY OF COVERED CARE UNDER MEDICARE. EXCLUDES STAYS OF BENEFICIARIES WHO HAVE EXHAUSTED THEIR SNF BENEFITS AND FOR WHOM NO DISCHARGE RECORD WAS RECIEVED

TABLE 5

USE OF SKILLED NURSING FACILITY SERVICES BY MEDICARE HOSPITAL INSURANCE BENEFICIARIES: NUMBER OF COVERED ADMISSIONS 1/, COVERED DAYS OF CARE, COVERED CHARGES, AND REIMBURSEMENT FOR SELECTED DIAGNOSTIC CLASSIFICATIONS, 1984

DIAGNOSTIC CLASSIFICATION	ICD-9-CM CODE 2/	COVERED ADMISSIONS	COVERED DAYS OF CARE		COVERED CHARGES			REIMBURSEMENT		
			TOTAL IN THOUSANDS	PER ADMISSION	AMOUNT IN THOUSANDS	PER ADMISSION	PER DAY	AMOUNT IN THOUSANDS	PERCENT OF COVERED CHARGES	PER ADMISSION	PER DAY
ALL DIAGNOSIS		332,746	8,864	26.6	$975,362	$2,931	$110	$464,796	47.7	$1,397	$52
MALIGNANT NEOPLASM OF TRACHEA, BRONCHUS, AND LUNG	162	2,297	52	22.9	5,688	2,476	108	3,005	52.8	1,308	57
DIABETES MELLITUS	250	4,721	150	31.8	14,776	3,130	99	6,595	44.6	1,397	44
CHRONIC ISCHEMIC HEART DISEASE	414	3,591	109	30.5	10,333	2,877	94	4,699	45.5	1,309	43
HEART FAILURE	428	7,329	176	24.1	17,189	2,345	97	8,396	48.8	1,146	48
ACUTE CEREBROVASCULAR DISEASE	436	29,479	1,057	35.9	118,126	4,007	112	49,136	41.6	1,667	46
PNEUMONIA, ORGANISM UNSPECIFIED	486	4,578	118	24.7	11,608	2,536	103	5,135	44.2	1,122	45
CHRONIC AIRWAY OBSTRUCTION	496	3,386	80	28.5	9,157	2,704	115	4,040	44.1	1,193	51
DISORDERS OF URETHRA AND URINARY TRACT	599	3,366	95	28.1	9,012	2,677	95	3,970	44.1	1,180	42
CHRONIC ULCER OF SKIN	707	4,959	206	41.5	23,841	4,808	116	9,749	40.9	1,966	47
FRACTURE OF NECK OF FEMUR	820	29,588	970	32.8	105,494	3,572	109	52,712	50.0	1,785	54
FRACTURE OF UNSPECIFIED PARTS OF FEMUR	821	3,444	124	36.1	13,241	3,845	107	6,290	47.5	1,826	51
OTHER ORTHOPEDIC AFTERCARE	V54	3,090	80	26.0	9,568	3,096	119	4,880	51.0	1,579	61
ALL OTHERS		282,978	5,652	24.8	627,331	2,693	111	306,190	48.8	1,314	54

1/ INCLUDES SNF ADMISSIONS WITH AT LEAST ONE DAY OF COVERED CARE UNDER MEDICARE. EXCLUDES STAYS OF BENEFICIARIES WHO HAVE EXHAUSTED THEIR SNF BENEFITS AND FOR WHOM NO DISCHARGE RECORD WAS RECIEVED

2/ INTERNATIONAL CLASSIFICATION OF DISEASE, 9TH REVISION, CLINICAL MODIFICATION (VOLUME 1).

Sources and Limitations of Data

Data in this report are derived from a 100-percent count of billing forms submitted by participating SNF's for reimbursable inpatient SNF services. Data are based on records processed and recorded as of December 1985.

It is estimated that the totals shown for the covered days of care and reimbursements are approximately 95 percent of the eventual totals. Thus, the rates and averages shown may be less than would prevail were complete data available. Comparisons of rates should be taken as indicative of differences by relevant characteristics rather than as final measures of the rates.

Definition of Terms

Covered day of care - A day of inpatient skilled nursing care (SNF) during which the services (determined to be medically necessary) covered by Medicare were furnished to a person eligible for hospital (HI) benefits. The day of discharge is not counted as a day of care.

Admission - The formal admission of a patient into a SNF participating in the Medicare program. Admissions include those who died during a SNF stay or were transferred to another SNF. The admissions shown in this Brief reflect beneficiaries who received at least 1 covered day of SNF care under the Medicare HI program.

Reimbursement - Payments under the HI program are based on interim reimbursement rates reported on processed bills. The interim rates are established to reflect current costs as closely as possible. These are usually established as a per diem amount or as a percentage of the total charges. Figures shown exclude amounts for which the patient is responsible such as deductibles, coinsurance, and charges for noncovered services. The final amount of reimbursement due under Medicare to each provider of medical services is determined after the end of the fiscal year on the basis of the provider's audited reasonable cost of operations.

Covered charges - The SNF's covered charge for room, board, and ancillary services as recorded on the billing form (HCFA 1450 or HCFA 1453).

Skilled nursing facility - An institution providing inpatient skilled nursing and restorative care services which has a transfer agreement with one or more participating hospitals, and meets specific regulatory certification requirements. The SNF must be certified under Medicare in order to be reimbursed for skilled nursing care services.

State - Refers to the State where the beneficiary is living, not the State where he or she receives services.

Principal diagnosis - The principal diagnosis is the condition established after study to be chiefly responsible for the admission of the patient to a SNF. All diagnostic information shown in this Brief are classified according to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). Three, four, or five-digit codes are assigned for each principal diagnosis.

Recent releases

The following Health Care Financing Research Briefs were recently disseminated and are available upon request from the Office of Research and Demonstrations, Office of Research, Division of Program Studies, Information Services Branch:

- No. 85-1 - Medicare: Inpatient Use of Short-Stay Hospitals, 1983
- No. 85-2 - Hospital Outpatient Services Under Medicare: Trends and Demographic Variations, 1983
- No. 85-3 - Medicare: Use and Charges for Inpatient Services in Short-Stay Hospitals, by Diagnosis-Related Groups, Calendar Years 1981 and 1984
- No. 85-4 - Medicare: Surgical Procedures in Short-Stay Hospitals, by Census Region, 1983
- No. 86-1 - Medicare: Use and Cost of Home Health Agency Services, 1983
- No. 86-2 - Medicare: Participating Providers and Suppliers of Health Services, December 1985
- No. 86-3 - Raising the Age of Eligibility for Medicare to Age 67

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